Non Contracted Provider Payment Dispute Form

(APPLIES ONLY FOR DISPUTES TO UNDER MEDICARE FEE PAYMENT OR DOWNCODE)

(Please read instructions below)

PROVIDER INFORMATION

☐ Physician ☐ Facility Medicare ID: ☐☐☐☐☐☐☐☐☐☐☐

Provider Name _____ Contact _____

Rendering Provider NPI _____ Telephone _____

Billing Provider NPI _____ Fax Number _____

Member Name	Member ID	Claim Number	CPT/HCPCs	Date of Service	Prior Payment	Estimated Amount Due

Reason(s for dispute:

INSTRUCTIONS

The following documentation MUST be submitted with this form:

1. Form 1500/UP04
2. Copy of Explanation of payment
3. Provider Contact information including name and address
4. Pricing information, including NPI Number (and CCN/OSCAR number for institutional providers), ZIP Code where services were rendered. Physician specialty
5. If available: any supporting documentation and correspondence that support your position that the payment is not correct (this may include interim rate letters and/or documentation reflecting payment from Original Medicare and similar or identical services)
6. Copy of the provider's submitted claim with disputed portion identified

Choose one of the methods below to submit your Dispute Request:

Mail to:
Appeals and Grievances Department
PO Box 71114,
San Juan, PR 00936-8014

Fax to:
(787)-625-3375

Important information:

The time frame for disputing a reimbursement issue to the MAO Plan is 120 days form the initial determination date.

Requests that do not contain all required elements are considered incomplete and subject to dismissal. Waiver of liability is not a requirement for the dispute process.

Every dispute is processed within 30 days from the receipt date.

If you have any question, please contact the Provider Relations Department at (787) 993-2317 (Metro Area) or 1-866-676-6060 (toll free) from Monday to Friday 7:30AM-6:00PM

PROVIDER SIGNATURE: _____ DATE: _____